State Employee Benefits Advisory Council Meeting
June 23, 2011
Statewide Benefits Office
Dover, Delaware

The State Employee Benefits Advisory Council met on June 23, 2011 in the Statewide Benefits Office, 500 W. Loockerman St., Suite 320, Dover, Delaware. The following Council members and guests were present:

Brenda L. Lakeman, OMB, SW Benefits Director
Patricia Griffin, SEBAC Chair, AOC
Marsha Carson, SEBAC, DOS
Frederika Jenner, SEBAC, DSEA
Sandra Ogden, SEBAC, Agriculture
Ann P. Skeans, OMB, SW Benefits
Mary Thuresson, OMB, SW Benefits
Mary Cooke, DOE
Judy Anderson, DSEA
Jaime Conrad, Pfizer
David Leiter, state employee

Ms. Lakeman called the meeting to order at 3:02 p.m.

1. Approval of Minutes

Ms. Lakeman asked members to review the prior meeting minutes from April 14, 2011, and then requested a motion to approve them. Ms. Cooke made the motion and Ms. Carson seconded the motion. Upon unanimous voice vote the minutes were approved.

2. Update of SEBC Activities – Brenda Lakeman (handouts)

Since Ms. Lakeman did not attend the April 14th SEBAC meeting, she asked if there were any questions from it or the April SEBC meeting. Ms. Cooke stated they ended the prior meeting talking about if there had been any estimates done on costs associated with the Civil Union Bill. Ms. Lakeman replied not yet. In the past studies had been done when they had domestic partner bills. There will be some cost impact. States that have adopted domestic partner or civil union bills in the past have not seen an adverse impact. It's similar to adding spouses or children of spouses. She can find her past estimates and share them. Their concern was with respect to Double State Share (DSS). Ms. Lakeman stated after January 1, 2012 when this becomes effective, there is no more DSS. You have to be eligible for DSS as of December 31, 2011 to continue being DSS. So, there is no impact. They are working with PHRST, Pension Office and will work with DTC and UD who have their own payroll systems to implement this in the payroll system. At the current time, based on federal code, this will not be treated in terms of a deduction the same as an opposite sex partner spousal deduction since the federal government does not consider that domestic partner, civil union partner to be eligible for the same tax treatment. Detailed explanation was given.

The Open Enrollment (OE) update stated that OE was extended for two days, which helped to lessen calls after OE closed. The Consumer Directed Health Plan (CDH) had 736 enrollments, which was about one to two percent enrollment. They had hoped for more like five percent. Medicare eligible, over 65 and disabled population were not eligible for CDH. Not as many people switched to CDH as they had hoped for. There was a significant movement from the HMO plans into CDH, even though the premium is not much different. If managed correctly, they may save a lot on out-of-pocket co-pays, or co-insurance they would have had to pay in the HMO plan. Some DSS people also moved into it. Mr. Leiter asked if younger people switched into CDH. There was no breakdown for that, but it was broken down by salary brackets. The median salary was $45,803 and average salary was

$46,591. People making in the $20,000s up into the $100,000s switched to CDH. It was very well dispersed. Mr. Leiter stated the program would work well for younger people.

Concerning the dependents to age 26, there were an additional 1,519 dependents enrolled between 21 and 26 who were not enrolled before. In Blue Cross, between 21 and 23 there was a 32 percent increase in enrollment, with 738. All of Aetna's numbers were not in yet. An additional 148 enrolled, but they did not give a breakdown of before and new. Based on the average per member, per year costs, even if using the lowest, which is Aetna at $3,564 a year, we are around that $5 million mark or over in terms of what was our estimated spend. Blue Care HMO is $4,124 per year, PPO is $5,051 and First State Basic is only $2,206. Perhaps that number should be used as more representative of this population. The estimates come down. Using $3,000 as a compromise, that is $4.5 M.

The Spousal Coordination of Benefits (COB) report was received June 22nd. Blue Cross had 1,671 who did not complete a form which is 10 percent of the spousal contracts and Aetna had 264 who did not complete their COB forms. Those not completing their COB forms are sanctioned and the state only pays 20 percent of their claims until their form is completed. Letters are sent to instruct them to complete the form or the sanction remains in place.

The adult dependent coordination of benefits forms were new this year. Per Blue Cross 701 did not complete the forms. There are 3,378 dependents between 21 and 26 and it was 18.6 percent who did not complete the forms. Aetna had 102 who did not complete the forms and probably with a similar percentage. Letters will be sent out to those parents to fill out the form.

DelaWELL had a Wellness Champion meeting on June 22nd. Awards were presented and the next year's plan explained. There were close to 3,000 who completed the requirements for FY11 and got the incentive. About 8,000 people registered, 5,000 to 6,000 completed the wellness assessment, 4,500 did the biometric screen, but 3,000 got to the 20 points. Payouts will be in the July 15 paycheck.

Ms. Griffin requested an update on financial details for the Health Fund. Ms. Lakeman reported that as of the end of May there is a $30 M surplus, a little less than the prior month. Some months have more weeks than others, so more bills come in than others, but they don't necessarily get more income. The surplus went down about $5 M and there were no rebate payments from Medco, no additional Early Retiree Reinsurance Program (ERRP) revenue. It will probably rebound next month. The $43 M talked about for FY11 is different than the fund equity, which is an account balance. It's showing you money in, money out. The $43 M is all revenue in for that year and all expenses out for that year. The trend is at 4.1 percent, doing very well and staying about the same, flat. Nationwide the trend is around 8 percent, but some are lower. Some have aggressive wellness programs and it's speculated some are foregoing services. At the beginning of the recession many used a lot of services, now they seem to be holding onto their money. We cannot say this will be a long term trend, but we hope so.

Regarding the item to transfer to Other Post Employment Benefits (OPEB), there was discussion in February and March about transferring the FY11 Medicare Part D money into the OPEB fund. Ms. Lakeman explained OPEB means other post employment benefits and gave detail about what it was and how it came about. The Government Account Standards Boards now require states to put money away for future liability to pay for benefits. Each year the Pension Office has to determine the

future benefit costs for retirees and set aside money for it. The state is about $5 billion behind what should have been put in to fully fund those benefits. Money is deducted from employee pay. Another $9 to $10 M deposited into the fund will be beneficial. Since that money is now surplus, a motion is anticipated to move that money to OPEB. In 2007 or 2008 about $30 M was moved to OPEB. A large amount has not been moved since then. The Medicare Part D amount, per the financials, is $10.2 M. SEBAC may or may not want to comment on this at SEBC.

The ending motion to close the FY12 budget was to use the ERRP money in that every month the first $792,000 of claims would be paid out of the ERRP until it is exhausted. If exhausted then other one time revenue sources would be utilized. It was never specified the Medicare Part D money would be used. Ms. Griffin was concerned if that Medicare Part D money was needed to cover anything else. It was explained the $30 M in the fund balance did not include that $10 M. Questions and answers were intermingled. It is expected the SEBC will only ask to move what is currently in the fund, not what continues to come in. It was believed the Medicare Part D could be used anywhere for benefits and claims. Ms. Griffin asked if they anticipated any huge deficit for FY12, because once the money goes to OPEB it cannot be used elsewhere. Ms. Lakeman stated no, unless the trend changes or the federal government makes changes. Mr. Leiter asked if the Insurance Commissioner would be satisfied with that money. The $10 M, Medicare Part D is coming out of the surplus, which is different from the reserve. The reserve is $55 M, which is over and above the $30 M. FY12 funding was briefly discussed.

Ms. Anderson gave explanation concerning monies moved to OPEB. They run the risk of creating a tail liability in the health equity fund if that money is moved over. Because your plan is pay first dollar for the prescription and health care fees, the government is reimbursing you for that and lowering your plan costs to offset those costs. If you move this money for another purpose, you don't have that there to offset the costs in your plan. Ms. Lakeman informed that the Medicare Part D did not specify how it is to be used. Ms. Anderson asked if the intent isn't to offset what they already paid first dollar for. Ms. Lakeman said it already has. Discussion followed. It was explained that the $10 M stands alone and could easily be said to be part of the surplus, but we leave it in its own line so they always know what is in there, but it doesn't have to be in its own line. Ms. Griffin asked if it is a tail liability. What does that mean in terms of getting potential money in the future? Is there any downside? Ms. Anderson, upon consulting Mr. Barchak about a related 2009 report, stated the money is to be rolled back into the fund or it creates the tail liability.

GASB has requirements that money has to be put into OPEB and at some point we will have to be in compliance with GASB ruling. Ms. Lakeman stated yes, but they look at your liability and bond rating. They want to add money to decrease our unfunded liability.

There were proposed changes to eligibility and enrollment rules that would be presented for SEBC approval. The majority of changes were due to their requirement to update the rules as it relates to dependent age to 26. There were other changes also made, some due to language or typing mistakes. A handout of changes for consideration was reviewed. The SEBC will also have a copy of the rules with the red line changes. Ms. Lakeman fully explained each change and why it was needed. There were questions with discussion and answers.

SEBC will be updated on the ERRP program. A program overview was given. The state has received $5.7 M reimbursement so far. The estimate for FY12 total was $15 to $19 M. We had submitted two cost reports. These reimbursements were received. Early in April the federal government said it was now required to supply detailed claims data in order to get reimbursements. Detailed claims data also had to be provided for the money you have already received. They have been working with Medco, Blue Cross and Aetna to get this data. Some of the detail was not in our data mining database, which is where the information was pulled from. Some information was not captured by the vendors. There are four pieces of details needed. Until this data is collected and sent to us, which won't be until late August, we can't submit for the end of June. Once the data is received, the pharmacy and medical information will need to be aggregated. Then it can be sent to the Centers for Medicare and Medicaid. It will probably be September or October before another reimbursement is received. The concern is if the $5 billion in reimbursement funds could run out. All employers are probably in the same situation as us, needing to gather data. We are confident we'll have the information to send them in September. So far in FY11 we received $4.3 M. There may be federal legislation to increase that $5 billion by another $5 billion.

3. SEBAC Comment to SEBC

The SEBAC supports transfer of additional funding to OPEB to meet the state's OPEB obligations, so long as there are no unintended consequences to the health equity fund.

4. Other Business

It was explained that Pfizer (drug company) is helping the state, through Dela*WELL*, to roll out a tobacco cessation program with Dela*WELL* in FY 2012. They have already developed a program used with other employers. It is similar to a Weight Watchers program, but for smoking cessation.

SEBAC members were asked to choose a date for the November meeting. November 17, 2011 was agreed upon.

5. Public Comment

Ms. Anderson presented updated information she just received from Mr. Barchak concerning the Medicare Part D money usage. You are using money that's supposed to be used to offset current expenses, i.e. the expense of drugs for seniors and instead of using it in the current year you're using the money to pay for future applications when you move it to the OPEB fund. This creates the tail liability. It's the ground you are losing on keeping up with current expenses of maintaining the RX program for the seniors in your health equity plan. This point was raised by Millman when they looked at this is 2009. Ms. Griffin added that another way of doing it would be to take the same amount of money from the surplus.

Being nothing further, Ms. Griffin asked for a motion to adjourn. Ms. Carson made the motion and Ms. Ogden seconded the motion. Upon a unanimous verbal approval the meeting adjourned at 4:27 p.m.

Respectfully submitted,

Mary Thuresson
Administrative Specialist
Statewide Benefits Unit, OMB